TETTIME A.M. IND.  TETTIME A.M. IND.  TETTIME A.M. IND.  TETTIME A.M. IND.		OBITO OFINITIVITION	
	DOCTOR'S ORDER SHEET	DAGG SENSITIVITIES:	JE KNOWNY
Contains		New	
Continued   Cont		1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	
Output   O	#25.26	Manage	
Districtive   And   An			
One of the control			
10000000   10000000   10000000   10000000   10000000   10000000   10000000   10000000   10000000   10000000   10000000   10000000   10000000   10000000   10000000   10000000   100000000	DATE/TIME	Comments	
	D		
		AFRICA BROKE	
DATETINE  DATETI			
		M.D. Spridury State	
DATETIME  AMM NOTED BY  Comman  Marketonia  Marketonia	A STATE OF THE STA	aneq.	
MATTER BY MATER BY Command    A	INVESTMENT (1977)		
Control   Cont	LATELINE A.M.	Comments	Zew.
Overland		Medication	
DATE/TIME		# N 19 12 12 13 13 13 13 13 13 13 13 13 13 13 13 13	
MAD Expendent   Property   Prop	Cont. 8 Soll South	Dose & Route	
DATE/TIME		vol. 32. Some Some Some Some Some Some Some Some	4 19 10 19 10
DATETIME A.M. NOTED BY Commans  A.M. NOTED BY Commans  Medication  Mail Signature  M.D. Signature  M.D. Signature  A.M. NOTED BY Comments  Time of Order  Time of Order		Separature Separature Company of the	:
DATETIME A.M. NOTED BY Comments Medication M		Date Time of Order Secr	
DATE/TIME  DATE/TIME  AM NOTED BY  Comments	DATECTIME	Comments	
DATE/TIME A M NOTED BY Commens			
DATE/TIME A M NOTED BY Commens	CH 3 20 11 11 11 11 11	Medication Name Name Name Name Name Name Name Name	
M.D. Signature M.D. Signature M.D. Signature Time of Order Time of Order A M. NOTED BY Comments	And the second of the second o	Dose & Route	
DATE/TIME A M			
DATE/TIME A M NOTED BY Comments		Attent	
DATE/TIME NOTED BY Comments A M		Signature	
DATE/TIME NO		Time	
1	DATE/TIME A.M.	Comments	

NR 1613 8/82

### MONTEFIORE MEDICAL CENTER

# VITAL SIGNS - GRAPHIC SHEET

RECORD(1) TEMPERATURE READING IN RED

- (2) PULSE AND RESPIRATION READING IN BLUE
- (3) BLOOD PRESSURE V SYSTOLIC IN BLUE

900105770

N767974061LADI.RONI POB127MILBOURDEL NA 7041 P B. STRAUCH PLS 112643264 M39 H 011-972-5334 06443890 0003B121291

				– A DIAS	TOLIC IN BLU	JE			
DAT	E		12/12	13	14	15			<del></del>
TEM	IP. MOD	ε	- FANTAS - A		/				
	OR P.	м	AM RM		AM EM	AM PM	AM RM	AM PM	AM PM
HOU BLOOD PRESSURE	TEMP	PULSE	4 8 4 4 8 1	8 12	3 8 12 4 8 12	8 12 4 8 12	4 8 12 4 8 12	4 8 12 4 8 12	4 8 12 4 8 12
250	106°	180							
240	105°	170							
230	104°	160							
220	103°	150							
210	102°	140							
190	101°	130							
180	99°	110							
170	98°	100							
160	97°	90 .							
150	960-	80							
140	95°	70							
130	<del>-                                    </del>	éО.							
120		50	:	<u>/</u>					
110		46							
100		RESP.							
90		60	:   :   1 :   :   A						
80		li li							
70				1: : 2				1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
60 50			· - 385 Mar 1902	1::	6-04- 16-04- 16-04-			1 0 0 0 0	
40					188.56 FR 300 Broke				
30		1			Francisco Company				75 20 27 27 27
CVP					invests about likely.				
WEIGH	<u>T</u>							-006052	<del></del>

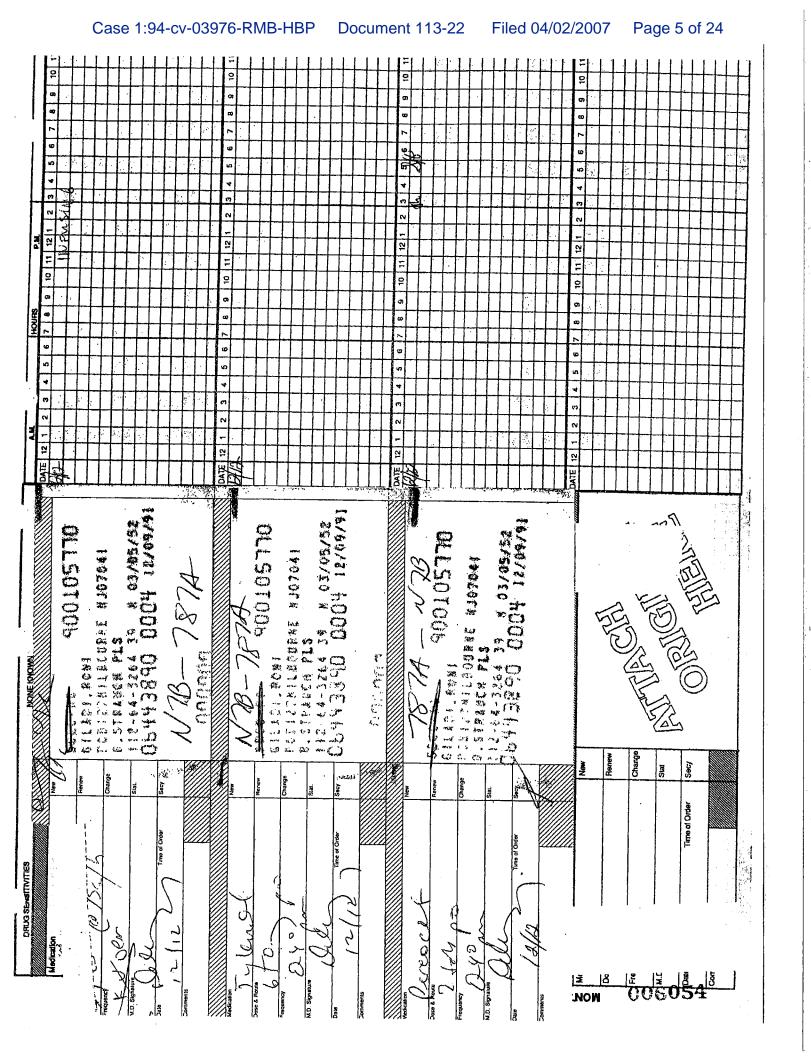
MONTEFIORE MEDICAL CENTER MOSES DIVISION DEPARTMENT OF NURSING

# PATIENT INTAKE/OUTPUT RECORD

DÄTE: 17-1	<u>3</u>	-9	/	_								י א P :	900105770  178787A GILADI. RON  312741LBOURN Endringsograph plate information T2643264 M39 H 011-972-5334  10111als signature
IV Lines		#	1	}		#2		ŧ	/3	L		P	B SIRAL BOUR N Enddressorrabh plate information
Type/Size											. [		T2643264 M39 H 011
Location of site	I.L	\$ 4	en								, i	<i>,</i>	972-5334
Peripheral IV insertion date	].	2	12								** .		initials signature title
Solution + Rate		,											
Site checked per standard	D	E	N	D	E	N	D	E	N	D	E	N	Name :
Peripheral IV site changed per standard								•					
Tubing changed per standard													
Dressing changed per standard													

	Solu	ution			line	line	line		NG/G	ì	TOTAL
	line #1	line #2	line #3	Time	#1	#2	#3	l	tube	ORAL	IN
LIB				7 A			77				
				8 A							
				9 A				-			
				10 A		T .					
				11 A							
				12 N							
				1 P							
				2 P							
				TOTAL							
				8 hrs	<u> </u>			_		ļ	
LIB	11		<u> </u>	3 P	ļ					<u> </u>	
				4 P						<u> </u>	
				5 P						<u> </u>	
				6 P						·	
LIB				7 P					ļ.,_	<u> </u>	
<u> </u>				8 P						_	
				9 P							
				10 P							
				TOTAL 8 hrs							
LIB				11 P							
<del></del>				12 M							
				1 A						T	
				2 A							
				3 A							
				4 A							
			,	5 A							
				6 A	1						
				TOTAL 8 hrs							
				TOTAL							
				24 hrs	-		-   "			1	

			Wound	TOTAL
URINE	EMESIS	NG	drain	OUT
			<del>  -</del>	
	<del> </del>		<del>  </del>	
			<del> </del>	
	<del> </del>		<del>  -</del>	
			<del>                                     </del>	
			•	
			† <u>-</u>	
	<del> </del>		<del>  -</del>	
	-		<del>├──-</del>	
	ļ		<del>                                     </del>	
	<u> </u>			
	T			
			<del>                                     </del>	
	<del> </del>		<del> </del>	
	<del> </del>	-	<del>}</del>	
	1	l		
-,	<del>                                     </del>	-	<del>  </del>	
	1	ļ.—	<del>  -</del> -	
	<u> </u>	<u> </u>		
		1		
	<del> </del>		1	
	<del> </del>		++	
		<b> </b>		
			1 1	
	<del> </del>		· <del>    -</del>	
				] "']
		1	1 1	1 3



NR-79	Montefiore Medical Center  Moses Division  3505-88  900105770
	Moses Division 3000-98 400105 1 10 Same Day Care Center CILLUI. RONI
	Nursing Assessment/Admission Interview  PCE127#11800RNE NJ07041  B.STRAUCH PLS
	112-64-3264 39 K 03/05/52
	06443890 0004 12/09/91
	Maria William Commencer Co
	Scheduled procedure: Ambor SDA _Date: Z - / Z - Z
	Scheduled procedure: Ambor SDA Date: Date:
	Attending Physician: Medical Attending:
	Designated responsible party (Indicate for all procedures)
	Name: Relationship:
	Information obtained from patient family Interpreter by phone
	O(6)
	Pre assessment V/S: T PRO PRO B/P PRO Ht 5 Wt Date: 12-7-9/
	Allergies: No Yes Unknown (if yes, indicate substances)
	112111
	$\omega_{\kappa}$
	Past Medical, Surgical, Psychiatric History:
	854: Cell 17 01 (1, 20)
	Tour World World
	Copie Comment of the Copie of t
. 4	
	SMH'r ()
•	
	Present Medications: Uses aspirin or aspirin products No Yes (specify)
	De to suntiment OS TID.
	Present Medications: Uses aspirin or aspirin products No / Yes _ (specify)  Palipponi ly current OS T/D.

Transfusion History: No Yes \_\_\_ (please specify) Smoke?\_ \_ (no/yes) How much?

How long?

Substance abuse (alcohol or drugs):

008056

-3-

E.E.N.T.: Glaucoma	, IOL, prosthesis (type & location), current earache/discharge,
nasal congestion, so	re throat, recent URI, voice change, other
Neurological: Head	aches, tremors, seizures, vertigo, motor deficits, sensory
deficits	, other
Infectious disease:	Hepatitis, tuberculosis, AIDS, venereal disease,
other	
Mental/Emotional:	Anxiety, depression, insomnia, lethargy, hallucinations, disorientation, memory loss, other
Skin integrity: Lesio	ns, scars, rashes, ecchymosis, decubit, (describe and give location, ), other
Patient Profile:	394 old Hall or
	A) recent (" Celan
$\left( \right) $	$\frac{1}{2}$

			e.	THE SECTION AND ADDRESS OF THE SECTION ADDRESS OF THE S					
		GULLED RONI	P. 8. STRAUCH PLS 112643264 N39 N 011-972-5334 054438999999998121291	# DAY #	DAI E				
	ر د		T.S. O.I.I	ielk					
	187	A GILL	3264 X3	DAY#					4
		1 1	- 12643 - 12643 - 12643	Ĕ					
. ij	•	Lan Andrija	Caldi	DAY #					
Ŋ N	al Signature			ĬĊ				,	-
ON - DEPARTMENT OF NURSING	RN Initial			DAY # DATE:			-		
RTMENT	-		errondo (	Init					
N - DEPA	Signature		Mason	DAY # DATE:					6
S DIVISIC	RN Initial			Æ					
ROBLEM	R. I	i Y	De .	DAY # DATE:					
MONTEFIORE MEDICAL CENTER - MOSES DIVISI NURSING PROCESS PART 3; PROBLEM 1 IST	ons for evaluation: Each problem/need is assigned its own	number and box. Designation for continuation of problem/need from day to day is "" Resolution of problem/need is	designated by 'Ø' . Change in labeling of problem/need is designated by '△ ·	8: 8:	ention confort pain	alteration real of the Contraction of the Contracti	then involve	to the state of th	
FIORE MED G PROCES	Instructions for evaluation: 1. Each problem/nee	number and box. Designation for c problem/need fro Resolution of pro	designated by 'Ø · Change in labeling of is designated by · △ ·	int DAY# DATE:	Olleration	Pot a in circs stains	Pot.	ر کولیک کولیک	
MONTE	Instruction 1.	તાં જ		Problem #	Z Ø Ø C	0 × ~ v u o u		ш ш О o	

		•	**SKKRS1 L
DAT	E: 13 13 13 TIME: cuebox	7-3	$\square \qquad \square \qquad \square \qquad \square \qquad \square$
NUR	SING PROCESS FLOW SHEET COMPLETED BY:	3~11	700000000000000000000000000000000000000
pognosino, -	The Company of the State of		- 181 Agoicas Arbo
initial		11-7	
PLAI	N OF CARE REVIEWED BY:		POBI 27 HIL BOOG A POPO POPO POPO POPO POPO POPO POPO
			P B STRAUCH PLS 112643264 H39 H 011-972-5334
initial	s signature title print name		1 05443890 0003B121291
	DATA COLLECTION		NURSING DIAGNOSIS/PATIENT NEED/PROBLEM
	COGNITIVE/PERCEPTUAL		THO TO THE DIAGNOSIST A TIENT NEED/FROSCEM
S	Awake & Alert: Y N		(.14 +
E	Oriented to Person Y N Place Y N Time Y N Sensory perception limitation: complete very limited slightly limited nor	۱. II	alteration in comport
S	Environment: adjust for patient Y N	"	RT Davis
0	Pain/Discomfort: Y N		The state of the s
R	if yes, describe:		
	Other:		
	ACTIVITY/EXERCISE	<del>~~./////</del>	
С	Heart Rate: regular irregular		0+-0 0+7
R	Chest Pain: present not present Edema: Y N		lotential attention
С	if yes, describe:		in Circulation status Pr
U			1
L A	Peripheral Pulses Present: Y N if no, describe:	-   -	different purily
T	,		ľ
0	Capillary refill: normal prolonged		
R Y	If applicable, complete: Cardiac monitor rhythm:		
	Other:		
		}	
V E	SOB: Y N		0 + - 0 0 1
E N	Dependent on O2: Y N Cough: Y N if yes: productive non-productive		Patential for Past-op Respiratory status
T	Cough: Y N if yes: productive non-productive lif applicable, complete:		Respiratory status
ı	Trach # Endotrach #		- Story and Story
L A	Other:		
T			
1		-	
0			
N			
М	Mobility: completely immobile very limited slightly limited no limit	-	
0	Transfer self 1-person/assist 2-person/lift		
В	Activity: walks frequently walks occasionally chairfast bedfast		
r L	Gait steady: Y N Feeding: self assisted spoonfed not applicable		
ī	Other:		_
T			A
Υ.			
	"		
			000000

	post-oblik	ost hi	nocedule
DAT	E: /-//-//-//- TIME: cuebox	7-3	□ 7874 C 1 0
NUF	SING PROCESS FLOW SHEET COMPLETED BY:	3-11	787A Gyladi 900105410
		1 <sup>2</sup> 17	for the contract of the contra
initial	a signature title britt name	11-7	'N 1878' A GILADI. RONI POBLE 7 NIL BOURNE and the of the off
PLA	N OF CARE REVIEWED BY:	, i	P 8.STRAUCH PLS 112643264 839 # 011-972-5334
initial	s signature title print name	F	06443890 0003B121291 🚆
	DATA COLLECTION	<i>i</i>	NURSING DIAGNOSIS/PATIENT NEED/PROBLEM
S	COGNITIVE/PERCEPTUAL Awake & Alert: Y N	1881	
E.	Oriented to Person Y N Place Y N Time Y N		
N	Sensory perception limitation: complete very limited slightly limited none	, 📓	
s o	Environment: adjust for patient Y N		
R	Pain/Discomfort: Y N if yes, describe:		
Υ			
1	Other:		
Ì			
		╢	
Secondo			
	ACTIVITY/EXERCISE		
C	Heart Rate: regular irregular Chest Pain: present not present		
R	Edema: Y N		
C	if yes, describe:		
L	Peripheral Pulses Present; Y N		
A	if no, describe:		
T			•
O R	Capillary refill: normal prolonged If applicable, complete:		,
Y	Cardiac monitor rhythm:	-	
	Other:		
٧	SOB: Y N		
E N	Dependent on O2: Y N Cough: Y N if yes: productive non-productive	-     -	
T	if applicable, complete:		
i	Trach # Endotrach #		
L A	Other:		
T			• •
1		-  -	
0			
N			
М	Mobility: completely immobile very limited slightly limited no limit	#	
0	Transfer self 1-person/assist 2-person/lift		
В	Activity: walks frequently walks occasionally chairfast bedfast		
i L	Gait steady: Y N Feeding: self assisted spoonfed not applicable	-   -	
ī	Other:		
T			
Y		]  _	
•		-  -	- 0.2000
•			008060

# MONTEFIORE MEDICAL CENTER **MOSES DIVISION**

DEPARTMENT OF NURSING

All patients should have data collected and Braden Scale completed on admission, weekly, on transfer and Complete information for each pressure sore; assign letter to each on figures. after surgery.

Patients with Braden Scale score of 16 or less must have skin care protocols initiated.

Initial data collection and sign on reverse with title.

mi

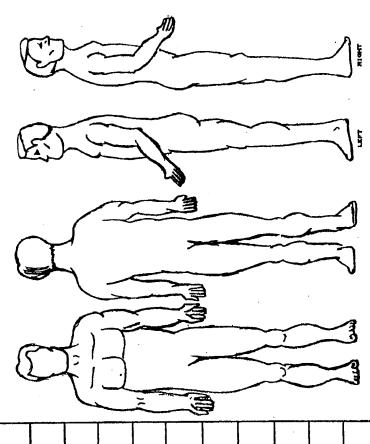
۲,

2

	ANY HEDDENE	OVIIV
	AGE	
	Necrosis Nurse's STAG	Initials
	rosis	₽
	Nec	Yes
	age	NG NG
	Drain	Yes
	Diameter Drainage	VxH (cm) Yes No Yes No Initials
		Stage
SISO WILL LING.	Letter	d Location Stage VxH (cm) Yes No Yes No Initials
טון מווס איטון טון ופעפואם אינוון וווים.	Sore Date First	Observe
- TO	e Sore	2
ta conec	Pressur	×es
ntial da	Braden	Score
4.		Date

ED AREA, BLISTER OR UNBROKEN STAGE II: £ Šes 욷 **8** Stage VxH (cm) Location to

SKIN HAS BROKEN INVADING THE SUBCUTANEOUS TISSUE. SKIN HAS BROKEN THROUGH TO THE SUBCUTANE-SKIN HAS BROKEN INVADING THE BONE AND MUSCLE. OUS TISSUE (SUPERFICIAL). STAGE IV: STAGE III:



Á.1

00|6061

ļ

ののないないできない。

耄.

G468965770

011-972-53

N78787A GILADI, RONI POBI27MILSOURNE NJO7041 P B. STRAUCH PLS 112643264 M39 H 011-972

00038121291

06864490

ALTERED SKIN INTEGRITY ASSESSMENT

VR-7863 Rev. 10/91

MONTEFIORE MEDICAL C	ENTER
MOSES DIVISION	\$CC-88 900105770 6
PRE AND POST PROCEDURE PH	IONE CALL GILADI. RONI POBLEZANIL BOURNE AJO7041
Λ	B. STRAUCH PLS.
My XM DIN	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$
Procedure: VW 010 0	Date & Time:
Physician/Service:	Status:
	(AMB/SDA)
Pre-Procedure Phone Call: Date:	12/11 Time: 11/4 2
Check off as completed,	0 000 0 1 000
1. Arrival and procedure time verificati	on 930/ an m
2. NPO and medication instructions rev	viewed
3. No recent exposure to infections	
4. Transportation/Accompanying Party	Snot
5. No change in state of health since assessment OOTAL I	= 420-2135 Till 43 Camalle co. work
	Signature & Title 125 Cmg Signature
Post Procedure Phone Call: Date:	Time:
General Stuatus Review:	Problems/Description
Activity	
Nausea/Vomitting	· · · · · · · · · · · · · · · · · · ·
Increased Temperature	
Pain	
Operative Site	
Other	
- Julio	
Torriments:	
Comments:	
	Signature & Title 006062
	Signature & Title

Signature & Title

# MONTEFIORE MEDICAL CENTER MOSES DIVISION SAME DAY CARE CENTER

# PRE PROCEDURE INSTRUCTIONS: (circle appropriate)

	* \ \		TO TRAILE PIECE AJORGA
	Α,	•	The same of the sa
l.	a.)	Adults:	Nothing to eat or drink (not even water) after midnight, /Z-//-// (date)
•	Ъ.	Pediatrics:	Nothing by mouth after (time),
			(date).
2	a.		adult must accompany you to and from the hospital.
	b.	Make arrangem procedure.	ents to be with a responsible party for 24 hours after the
-3	Chile		a parent or guardian accompany them to and from the
	hospi	Ital, and avai	lable on the Same Day Care Center at all times.
14.		casual clothi	
5			y, or bring valuables to the hospital.
/6.			p or nail polish the day of the procedure.
7.			ian, or the SDCC, if symptoms of a cold, fever, or any type
	of in	fection devel	op. We will call withing
8-		e be prompt:	
/ <b>9</b> /			Center will notify you the day before the procedure if any
			our scheduled procedure time. If you will not be home,
			SDCC to confirm your procedure time.
10.	Other	instructions	•
	11	) 40 M	SCITTLY TO MOPSEN
		× / /	Children on a set of the
	برسید. سرسیکی	Stop"	THE THE STORES COMO
		6 6 830	Mary Cont & ON All All Control
	1	- to the U	Complete for a factor of the
	•		
		<del></del>	
			·
	<del></del>		
			<del></del>
If yo	u hav	e any question	ns, please contact the Same Day Care Center at 212-920-5596.
•	,		,
		•	
	I und	erstand the al	pove instructions:
			lan: Date: 12-9-5
	pro minim	Patient/Guard	lan: Date: /
		Relationship t	o patient:
			given 100
			Signature & Title
			SIXHOFRE G ITFIE

•					•	
整有了整体的 (1.66%)。 《香港·日本》(第二条)			Bartha Miller	rich (Transfer Historian Fried		
	red in the tarreel. En in a viet in the	12/9/9/	eran er og av det er	989 - 30073 9007 <b>8</b> 9	6.6547+96+9 66447989+ <sub>1</sub> ,	50 q 60 3
* \$1115,112 (1) 13 * <b>\$2.0</b> (1)	-04 POS EZŹ RIELBOURAS	. No 67041			A 578 A 7. N: -10-64-3: p: 909-057-	1.4
HONE PRO	DMS: (DO:) <del>78e</del>	-7697.			B 03/05/-9:	
	FR . E. SINSTERNET SSS. CHEKNOWN		4	Charged (	9420 435-94 -	f 94
· TROUSE 19 NY 《作LO			fali	Or princes	N W	
FROHERTS AS Emily 10			Vi	May se	N	e ₹* .*
NOTIFIER A CO ENGLOS	ANDER ANDS ER			28	N	
	TO THE STATE OF T	· Tuthita	INFORMATION	· A市集市市市 · A市集市市市	Au 16	trus a full med.
05 AGW(\$73)	ELMMERGESCH (E.	.NA MEGVE L	ERT FLECV A	WF 107 YEAR	NERVI	. 10.73
新新加加斯克·纳纳克	OBSTANTA CLASSIAN AVERAGE	TENA MERVO DRIBT A LI	& TWANS PO , MEDIAN NE	CTION OF EL	BOW. HUEROL BOTOMY HE	: <b>5</b> 1.
今许·00代	AMO: BT PUCH, 1 199 PUB: WAIN! 148 (110) 986-	PEDAR OVE	, BRONX . NY		SERVICE: F. 16 REQD: D	
	<b>新热力强产</b> 。	- FINAGOIAL	SHFORMATIC	)(1) 特别强制统件		
MUDICARE 6	EFFECTIVE DATE		GN CARD:	PART B.	off one the first the part one are as a first	
**************************************	· · · · · · · · · · · · · · · · · · ·		ON CHRD	OR 100 per -01		· .
51.04 07.085 61 40 080 1	H DOMBLEAUXO SELT ADME GIR SEMBLONSE: FI	LADI ROSI	NOT SAME.	an a	(4 ) (4 ) (4 ) (4 ) (4 ) (4 ) (4 ) (4 )	
90 TO 120ME &:				Police Con-		
in the line of the state of the	GAME, PMOLOVEK			Y Life		
<b>野</b> (日) (1	2010N AMMER 133 11/25/42304 14/25/42304 14/25/14/49-14/15 10/47/14/15/15/16/16/16/16/16/16/16/16/16/16/16/16/16/	MAI DAI	erit beta	C	Σ <del></del>	
THE WARRENCERS	্যটুড়াল ১৯০০	• •	arme kangga	787 : (	006	064
or Johnson	Sagar S			and the effective ranks of the same and		

MONTEFIORE MEDICAL CENTER - MOSES DIVISION DEPARTMENT OF NURSING	900105770				
N / S / C / A   R / I	ADI, RONI UPHE NJOZOWI				
Admission date: /ec//ec/// Discharge date. /-c//_////	DENE NJO7041 PLS Programpipale (Information) 72-5334 COOB 3121291				
I. DISCHARGE STATUS Vital signs: BP: 1/0/60 T: 99 P: 78 R: 00					
Mental Status: Awake & Alert (Y) Oriented to: Person (Y) N Place Environment: needs adjustment: Y N describe:	Y N Time N				
II. ABILITY TO PERFORM ADL ADL Self Assisted (including devices) Dependent Restrictions	IV. REFERRALS (check all that apply) private M.D.				
Transfer  Dressing  Ambulating cane crutches walker w/c other  Feeding	name date: time:				
Bathing Toileting Position Change	clinte				
Gait steady Y N Bedfast: Y N Chairfast: Y N  III. PRESCRIBED REGIMEN  Diet (C) . Comments/Restrictions	name date:				
Medication (name) dosage route time to be taken	time:				
	home care				
	□ vns				
	Other:				
Action & Side Effects of medications were reviewed? Yes	Return to School/Work date:				
Action & Side Effects of medications were reviewed? Yes Specialized Treatments Frequency	uuto.				
V. WOUND/SKIN INTACT? Y (N) describe all non-intact skin  (DARM = & SPCINT & CAST = Ace Wrap & DSG D/I	SUNG TO WARM				
VI. MEDICAL ASSISTANCE  Call for medical assistance it: THEMP FEET Arounage on DSS Numbers Escasification for					
Options to obtain medical assistance in case of emergency discussed?  VII. STATUS OF PROBLEMS/NEEDS					
List unresolved problems/needs and indicate plan of care to be followed post-discharge:  Problem/Need Plan of Care Post-Discharge					
#1 POT ACT IN TISSUE AWARE S/S & & TISSUE PRATISION					
#2 Pot intection RIG INVASIVE PRECEDENCE HUMBE S/S of Infection.					
#3 ALTIN CONFRET RIT TRISTRUCTED TO TAKE TYLENDE 2 tabs QUH PERPA					
#4					
VIUS ADDITIONAL COMMENTS/DIRECTIONS (SOLD) NEURO-VASCULAR SEARS (D) HEM. Ofingers Slug	intly Swillow				
YOUR DISCHARGE APPEAL RIGHTS ACCORDING TO FEDERAL AND NEW YORK STATE STATUTE ARE DETAILED ON THE BACK. THIS DISCHARGE PLAN HAS BEEN REVIEWED WITH ME. I HAVE RECEIVED A COPY OF THIS PLAN AND A COPY OF THE DISCHARGE APPEAL RIGHTS MECHANISM.					
12/3/91 XIM	12/13/A)				
signature of patient or patient representative/relationship date RN signat	ure date				

# MONTEFIORE MEDICAL CENTER RESERVATION INDATIENT ADMISSION

	INPATIENT ADMISSION 5
CS	PATIENT'S LAST NAME GLOCIE FIRST Kore MI ADM. DATE
APHI	ss.# 112-64-2364 il/14
	DOB 3 - 5 - 52 RELIGION FEMALE MALE
2	ADDRESS P.O. By 127 TEL# 201 576-7697
S	BOROUGH Wellows STATE N ZIP 07041
끰	PATIENT'S EMPLOYER TEL#
	ATTENDING Strauch PHONE 5551 MADE BY Angela
ON	ADM. TYPE: EMUREL SERVICE PLSBED TYPE
I	Romania Com aleaning allows here last Ellowy + Whent
MA	PROCEDURE 1) rue 10 kins in alma verne left arist 14 / 91 an trans position at Elbon
J.H	BIAN OF CARE?
NFORM	REASON FOR PBE)OP 11 h. Medigns Name and Cynonectomy et When
=	PRE ADMIT TEST NO ALL CHEST X-RAY NO YES X-RAY DIAG
ON	DIET (FIRST 24 HOURS) KOSHER DIET YES NO
SIC	PREVIOUS MMC HOSP YES NO WHEN
IIS	SPOUSE'S NAME DOB
DN	SPOUSE'S EMPLOYERTEL#
A	PARENTS: MOTHER FATHER
ACC	T# <u>06443890 - 3</u> ROOMPT CALLED IN ATBY
	PRO REQUIRED YES NO DATE SENT / /
,	EFF. DATES
*! *!	LINE #   MEDICAID # NAME ON CARD EXP DATE
ш	BLUE CROSS # HOLDER EFF DATE
	BLUE SHIELD YES NO
X	INSUR CO/UNION NAME 1/99 ADDRESS
5	POLICY # HOLDER HOLDER
NSURANC	NAME OF PERSON TO VERIFY INS TEL #
	FINANCIAL CLEARANCE: YES NO BY:
	DEPOSIT REQUIRED:
ĺ	COMMENTS:
	UMBER (212) 920-8451 RESERVATION CLERK:

	ST-5		
ĘV.	12/8	4 PATIENT VALUABLES CHECKLIST	
	INST	RUCTIONS FOR USE:	900105770
	1. C	OMPLETE THIS FORM ON ADMISSION AND UPON TRANSFERS	1
	2. F	OLLOW PROCEDURE FOR VALUABLES, WHEN APPLICABLE. HEN PERSONAL PROPERTY DOES NOT ACCOMPANY THE PT.	RR CILADI, RONI ROBI 27 MIL BOURNE NJO7041
	3. W	E.G. TRANSFER TO OR/RR), COMPLETE BOTTOM SECTION.	B. STRAUCH PLS 011-972-5334
	•	12/12	1
		UNIT	06443890 0003B121291
		VALUABLES ENVELOPE# ITEMS TO SECURITY DEF	
	·		4
Z		NO CLOTHING WITH PATIENT	NG TAKEN HOME BY
SIC		NO VALUABLES WITH PATIENT	SLES TAKEN HOME BY (SIGNATURE)
PRE - ADMISSION	لسا	NO VALUABLES WITH PATTER!	TEMS) (SIGNATURE)
Ą		CLOTHING/VALUABLES RETAINED BY	
Ä	ld	CLOTHING/VALUABLES RETAINED BY PATIENT (COMPLETE SECTION BELOW)	
Ď,		PATIEN	T MEDICATION SENT:
	ITEN	AS TO BE RETAINED BY PATIENT:	COAT SHOES
		MONEY (AMOUNT IF OVER \$10)	
		5 6	OTHER IMPORTANT ITEMS (DESCRIBE)
	, 🔲	JEWELRY ( DESCRIBE)	bants, Shit
		<del>-</del>	
			extract crock (1),
Ö	П	DENTURES () UPPER () LOWER () PARTIAL	
SS		DENTIONES () OF EACH () BOHER () FIGURE	
ADM I SS I ON		EYEGLASSES ( ) PAIRS ( ) CONTACT LENSES	S.P.
₹		SPECIAL DEVICES/PROTHESES, AMBULATION	
		AIDS. HEARING AIDS, WIGS	1 Time Con
	٠		Jan
	١.	(LIST ITEMS)	
	<u> </u>		(EMPLOYEE SIGNATURE & TITLE)
	T	I have been advised to deposit all valuables in	
		Laccept full responsibility for anything kept a	t the bedside.
		I have no valuables with me.	A COLOR
	$\Box$	I refuse to deposit my:	<u> </u>
	ш	STATE ITEM (B) PATIENT SIGNATURE	(OR RELATIVE OR RESPONSIBLE PARTY)
		TOLITICAL OF DEPONIES CLOSELING/OR TO LITTLE DEPONIES	
	DIS	POSITION OF PERSONAL CLOTHING/OTHER ITEMS RETAINED	D BY PATIENT, UNIT.
		PATIENT TRANSFERRED VIA OR/RR. CLOTHING/PERSONAL	PROPERTY SENT TO:
			DATE
z	الا	CLOTHING/PERSONAL PROPERTY TAKEN BY RELATIVE:	NAME DATE
710		CLOTHING/PERSONAL PROPERTY SENT TO INFORMATION DI	ESK/SECURITY
: DISPOSITION			DATE (LIST ITEMS BELOW)
R	l		
5			
	1		006067
	L.		00000
		,	EMPLOYEE SIGNATURE AND TITLE

P.O. Box 127 Millburn, New Jersey 07041

SS# I12 64 32 64

2/25/91 Pt. is a 39 year old ex Israeli CAptain now a video photographer at Albert Einstein who on Sept.5, 1987 had a penetrating injury to his forearm with an incomplete severence of his left mediamerve. Sixteen days later he underwent improved considerably, and though he has 8 out of 10 in all of his digits except for the second web space where he has a 6. He has almost a complete absence of sensibility of the distal portion of the long finger on the radial side.

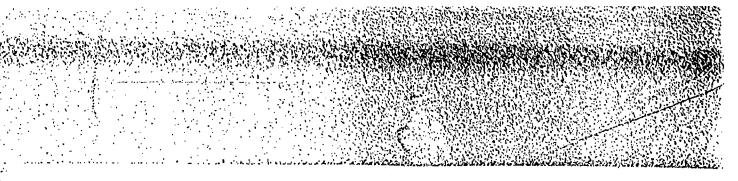
Pt's main complaint now is not sensibility but a weakness of his hand after prolonged use. On physical examination I cannot determine any loss except for for EMG's and conduction studies of his median and ulnar nerve.

7/19/91Pt. return today for further evaluation. Pt. has extensive findings objectively with evidence of mild bilateralmedian nerve compression at the wrist and plans compression at the elbows. Nevertheless Pt. has aches and pains that are not compatible with compressive neuropathies, as well as an additional complexity of an upper neck injury, as well. On physical examination, PT. has decreased sensibility, though clinically he does not report decreased sensibility only weakness and pain. His decreased sensibility is present in the hand on all



of his digits and Pt. has positive Tinel and positive Phelan, as well as weakness of his thenar musculature and his long flexus to the little finger. Under sterile conditions, the left carpal tunnel injected as a test to whether any improvement can be effected.

- 7/31/91 Pt. was mildly improved with the Carpal Tunnel injection. Pt. to return here in Spetember if no significant improvement and we will schedule for left median nerve decompression and ulnar nerve decompression at the elbow.
- ©9/4/91 Pt. needs a letter To Whom it May Concern explaining that he needs a decompression of his left median nerve at the wrist and the left ulnar nerve at the elbow and wrist.
- 10/11/91 Pt. schedule for ulnar nerve transposition at the elbow, ulnar nerve release at the wrist on the left side and median nerve release. The risks benenfits and alternative of this procedure discussed fully with the pt.
- 12/11/91 Pt. is pre-op for his ulnar nerve, neurolysis of the elbow and wrist as well as neurolysis of the median nerve at the wrist. The risks, benefits and alternatives discussed fully with the pt.
- 12/18/91 Pt. comes in today with decreased sensibility of his little finger which is peculiar because he had normal sensibility up until time of discharge from the hospital. Pt. feels that perhaps he has been resting his arm on the nerve . I believe this should be a temporary phenomena. Will re-observe and re-test.
- 12/23/91 Dressing re-moved. Wound is healing well. Redressed and resplinted.
- 12/27/91 Doing well. To return in one week for removal of splint .



Ron Giladi

#### CARD II

- 1/3/92 Now 3 weeks post-surgery. Doing well. Sutures removed. Will return to work in another three weeks.
- 1/17/92 Still has some edema and inability to make a full fist. Have referred him to Ann-Lang for physical therapy.
- 1/24/92 Doing well. Has a tinel in the little finger and though he has full passive range of motion, cannot actively flex with great strength.
- 2/14/92 Pt. still has a stiff hand and is unable to work. To Continue working with the Hand Therapist and to return in to weeks.
- 3/4/92 Pt. is doing reasonably well, able to go back to work but still needs to maintain his physical therapy.
- 3/13/92 Sensibility of the little finger is 10/5, still undergoing rehabilitation efforts to increase his ROM.
- 1/3/92 Pt. complaining of burning and pain at the elbow incision. Has good dorsal sensibil and returning sensibility of his little finger. Complains of no power or strength i his arm.
- 5/13/92 Doing well. Developing increasing sensibility of his fingers. Now has a 10/4 which affords him good protective sensibility. Sensation on the dorsum of his hand is normal. Pt. is developing increasing strength of the flexor pollicus longus tendon of the little finger. Still has some aches and pains around the elbow.



- Pt. still has difficulty using his ulnar innervated left ring and little fingers. Pt. would find it difficult if he had to be faced with a situation in a military un
- 8/28/92 Pt. still has weakness of the ulnar innervated musculatrue giving him a markedly weakened grip. I do not feel that he can perform his usual army activities especial in an emergency situation where full strength capabilities of his left hand would be required.
- Pt.s says he was traumatized by his ex-wife in his left upper extremity several da ago. Pt. has various aches and complaints. Have started him on Motrin 400mg TID.
- Was seen in Israel where he had EMG's and Conduction studies. He was told he had a 1/15/93 injury to his ulnar nerve at the elbow. Pt. given the original EMGs to send to Israel for comparison. Have sent him back to Dr. Berger for repeat studies here so we can compare pre-op and post-op on the same apparatus. 811.193 no Show letter sind. Ew
- 10/6/93 Pt. has increasing symptoms of median nerve compression of the right wrist. I have asked him to have repeat EMG's and conduction studies of his right median nerve. May need either steroid injection or surgery.

# BERISH STRAUCH, M.D.

PLASTIC AND RECONSTRUCTIVE SURGERY
AESTHETIC SURGERY

SURGERY OF THE HAND

PROFESSOR AND CHAIRMAN
DEPARTMENT OF PLASTIC AND RECONSTRUCTIVE SURGERY
ALBERT EINSTEIN COLLEGE OF MEDICINE
MONTEFIORE MEDICAL CENTER

3331 BAINBRIDGE AVENUE BRONX, NEW YORK 10467 TELEPHONE: 212-920-5551 FAX: 212-798-0909

1123 PARK AVENUE
September 1, 1992NEW YORK, NEW YORK 10028
TELEPHONE: 212-534-5550

To Whom It May Concern,

Re: Ron Giladi

Mr. Giladi was originally seen in February, 1991 and gave a history of a penetrating injury to his forearm with an incomplete severence of his left median nerve in September, 1987.

At the time of my examination, he had evidence of both median nerve and ulnar nerve problmes. He had both sensory and motor loss of his ulnar nerve at the region of the elbow, secondary to compression.

On December 12, 1991, he underwent a transposition of the ulnar nerve at the elbow and a release of the ulnar nerve at the Guyon's Canal. Additionally, he had a median nerve decompression and external neurolysis at the left wrist.

Post-operatively, he has done reasonably well, however, he still has weakness of the ulnar innervated musculature giving him a markedly weakened grip. I do not feel that he can perform his usual army activities, especially, in an emergency situation where full strength capabilities of his left hand would be required.

If there is any further information I can provide, I would be most happy to do so.

Sincerely,

erish Strauch, M.D.

BS:ew dictated but not read

ようマブリロコンロコ ミョフラン こうりょうほし

60E072

# MONTEFIORE MEDICAL CENTER

## HENRY L and LUCY MOSES DIVISION THE JACK D. WEILER HOSPITAL OF THE ALBERT EINSTEIN COLLEGE OF MEDICINE

Date		,	of Orace
Date		CONSENT FORM	
Time AM./P.M.  PERMISSION FOR OPERATIVE AND/OR DIAGNOSTIC PROCEDURE AND/OR TREATMENT  I hereby authorize Dr.  I hereby authorize Dr.  Or associates or assistants of his/her choice at Monteffore Medical Center to perform upon mei/the named above patient the follwing operation(s) and/or procedure(s)  **Lease Pentry on yree**  **Tenchys**  **Lease Pentry on yree**  **Tenchys**  **Te		(to be signed by patient wherever applicable)	PATIENT'S NAME /
PERMISSION FOR OPERATIVE AND/OR DIAGNOSTIC PROCEDURE AND/OR TREATMENT  I hereby authorize Dr.  I hereby authorize Dr.  Or associates or assistants of his/her choice at Monteflore Medical Center to perform upon mel/the named above patient the follwing operation(s) and/or procedure(s)  PLEASE PRINT OR TYPE:  The PRINT OR THE TYPE:  Th			Date 10/11 19 51
PERMISSION FOR OPERATIVE AND/OR DIAGNOSTIC PROCEDURE AND/OR TREATMENT  I hereby authorize Dr.  Medical Center to perform upon me/the named above patient the following operation(s) and/or procedure(s)  **LEASE PRINT OR YVE  **TEATH OR YVE			Time A M /P M
Intereby authorize Dr.  Medical Center to perform upon me/the named above patient the following operation(s) and/or procedure(s)  PLEASE PRINT OR TYPE  Many 1		PERMISSION FOR OPERATIVE AND/OR DIAGN	
/pubcedure(s) as may be purposeful for the advance of medical knowledge and/or education, with the understanding that my/the patient's identity remain anonymous and all photographs and videotapes remain the property of Monteflore.  Dr	Ι.	I hereby authorize Dr. The Common Medical Center to perform upon me/the named above patient the	Or associates or assistants of his/hor shair and
/pubcedure(s) as may be purposeful for the advance of medical knowledge and/or education, with the understanding that my/the patient's identity remain anonymous and all photographs and videotapes remain the property of Monteflore.  Dr		Menrolycic v Transposith	n Wha neve Dephow
and has also informed me of expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment. I have been given opportunity to ask questions, and all my questions have been answered fully and satisfactorily.  It has been explained to me that during the course of an operation unforessen conditions may be revealed that necessitate an extension of the original procedure(s) set forth in paragraph 1. I therefore authorize and request that the above named surgeon, his associates and/or assistants perform such related surgical procedures and administer whatever is necessary and desirable in the exercise of their professional judgement.  I have been informed that there are other risks, hazards, complications, and consequences that are attendant to the performance of any surgical procedure. I acknowledge that no guarantees or assurances have been made to me concerning the results of the above operation, treatment(s) or procedure(s).  I further consent to the administration of such anesthesia and/or blood transfusions as may be considered necessary. I recognize that there are always risks to life and health associated with anesthesia and blood transfusions and such risks have been explained to me.  I further consent to disposal by hospital authorities, or possible use for research purpose, in accordance with its accustomed practice, of any tissues or parts which may be removed.  I confirm that I have read and fully understand the above and that all the blank spaces have been completed prior to my signing. I have crossed out any paragraphs above which do not pertain to me.  Interpreter  I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed procedure/ operation, have offered to answer any questions and have fully answered such questions. I believe that the patient/relative/ guardian fully understand what I have explained and answere	-c	/procedure(s) as may be purposeful for the advance of medical	aping, televising, or other observation of the operation(s)
It has been explained to me that during the course of an operation unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) set forth in paragraph 1. I therefore authorize and request that the above named surgeon, his associates and/or assistants perform such related surgical procedures and adminster whatever is necessary and desirable in the exercise of their professional judgement.  I have been informed that there are other risks, hazards, complications, and consequences that are attendant to the performance of any surgical procedure. I acknowledge that no guarantees or assurances have been made to me concerning the results of the above operation, treatment(s) or procedure(s).  I further consent to the administration of such anesthesia and/or blood transfusions as may be considered necessary. I recognize that there are always risks to life and health associated with anesthesia and blood transfusions and such risks have been explained to me.  I further consent to disposal by hospital authorities, or possible use for research purpose;, in accordance with its accustomed practice, of any tissues or parts which may be removed.  I confirm that I have read and fully understand the above and that all the blank spaces have been completed prior to my signing. I have crossed out any paragraphs above winch do not pertain to me.  Interpreter if required  SIGNATURE  PRINT NAME  PRINT	<b>?.</b>	and has also informed me of expected benefits and complication forts and risks that may arise, as well as possible alternatives	ns (from known and unknown causes), attendant discom-
the results of the above operation, treatment(s) or procedure(s).  I further consent to the administration of such anesthesia and/or blood transfusions as may be considered necessary. I recognize that there are always risks to life and health associated with anesthesia and blood transfusions and such risks have been explained to me.  I further consent to disposal by hospital authorities, or possible use for research purpose; in accordance with its accustomed practice, of any tissues or parts which may be removed.  I confirm that I have read and fully understand the above and that all the blank spaces have been completed prior to my signing. I have crossed out any paragraphs above which do not pertain to me.  Interpreter if required  SIGNATURE  PRINT NAME  PRINT NAME  PRINT NAME  SIGNATURE  PRINT NAME  PRINT NAME  PRINT NAME  PRINT NAME  I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed procedure/operation; have offered to answer any questions and have fully answered such questions. I believe that the patient/relative/operation; have offered to answer any questions and have fully answered such questions. I believe that the patient/relative/operation; have offered to answer any questions and have fully answered such questions. I believe that the patient/relative/operation; have offered to answer any questions and answered.  PARAMES:  DATE  DATE  DATE  PRINT NAME		It has been explained to me that during the course of an operatate an extension of the original procedure(s) set forth in paragnamed surgeon, his associates and/or assistants perform such re-	tion unforeseen conditions may be revealed that necessi-
I further consent to disposal by hospital authorities, or possible use for research purpose, in accordance with its accustomed practice, of any tissues or parts which may be removed.  I confirm that I have read and fully understand the above and that all the blank spaces have been completed prior to my signing. I have crossed out any paragraphs above which do not pertain to me.  Interpreter if required  SIGNATURE  PRINT NAME  Witness  PRINT NAME  I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed procedure/ operation, have offered to answer any questions and have fully answered such questions. I believe that the patient/relative/  DATE  PRINT NAME  DATE	-		cations, and consequences that are attendant to the per- arantees or assurances have been made to me concerning
I confirm that I have read and fully understand the above and that all the blank spaces have been completed prior to my signing. I have crossed out any paragraphs above which do not pertain to me.  Interpreter if required  SIGNATURE  PRINT NAME  I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed procedure/ operation, have offered to answer any questions and have fully answered such questions. I believe that the patient/relative/ guardian fully understand what I have explained and answered.  PRINT NAME  DATE  PRINT NAME  DATE  PRINT NAME  DATE  DATE  DATE	•		or blood transfusions as may be considered necessary, ted with anesthesia and blood transfusions and such risks
I confirm that I have read and fully understand the above and that all the blank spaces have been completed prior to my signing. I have crossed out any paragraphs above winch do not pertain to me.  Interpreter if required  SIGNATURE  PRINT NAME AND CORESS  PRINT NAME  RELATIONSHIP IF SIGNED BY PERSON OTHER THAN PATIENT  PRINT NAME  I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed procedure/ operation, have offered to answer any questions and have fully answered such questions. I believe that the patient/relative/ guardian fully understand what I have explained and answered.  PRINT NAME  DATE  DATE  DATE	•	I further consent to disposal by hospital authorities, or possible tomed practice, of any tissues or parts which may be removed.	use for research purpose, in accordance with its accus-
Witness  PRINT NAME		I confirm that I have read and fully understand the above and my signing. I have crossed out any paragraphs above which do not	I that all the blank spaces have been completed prior to pertain to me.
Witness  SIGNATURE  RELATIONSHIP IF SIGNED BY PERSONOTHER THAN PATIENT  DATE  I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed procedure/ operation; have offered to answer any questions and have fully answered such questions. I believe that the patient/relative/ guardian fully understand what I have explained and answered.  PAGE  PRINT NAME  RELATIONSHIP IF SIGNED BY PERSONOTHER THAN PATIENT  DATE  DATE  DATE  PRINT NAME  DATE  DATE  PRINT NAME  DATE  DATE		if required	Guardian •
I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed procedure/ operation; have offered to answer any questions and have fully answered such questions. I believe that the patient/relative/ guardian fully understand what I have explained and answered.  Aysician  SIGNATURE  DATE  TO 1/1/5/ DATE  DATE		Witness (	
MARKS: SIGNATURE PRINT NAME DATE		I hereby certify that I have explained the nature, purpose, bene operation, have offered to answer any questions and have fully arguardian fully understand what I have explained and answered.	DATE (7/1/9/
	-	SIGNATURE	E STATICH 10/11/91 DATE
		· · · · · · · · · · · · · · · · · · ·	006023

# MONTEFIORE MEDICAL CENTER

HENRY L and LUCY MOSES DIVISION THE JACK D. WEILER HOSPITAL OF THE ALBERT EINSTEIN COLLEGE OF MEDICINE

## **CONSENT FORM**

Pori Giladi

(to be signed by patient wherever applicable)	PATIENT'S NAME /
	Date 7/19 5,
	Time A.M./P.M.
PERMISSION FOR OPERATIVE AND/OR DIAGNOS	TIC PROCEDURE AND/OR TREATMENT
	associates or assistants of his/her choice at Montafiero
PLEASE PRINT OR TYPE .	2 /
the car	pul tunnel
(Check if applicable) - including such photographing, videotaping /procedure(s) as may be purposeful for the advance of medical knowy/the patient's identity remain anonymous and all photographs	wledge and/or education, with the understanding of a
2. Dr has fully explained to n and has also informed me of expected benefits and complications forts and risks that may arise, as well as possible alternatives to the been given opportunity to ask questions, and all my questions have be	P DIDDOSED treatment including no treatment I have
3. It has been explained to me that during the course of an operation tate an extension of the original procedure(s) set forth in paragrap named surgeon, his associates and/or assistants perform such related ary and desirable in the exercise of their professional judgement.	h 1 I therefore authorize and require the the characters.
<ol> <li>I have been informed that there are other risks, hazards, complications formance of any surgical procedure. I acknowledge that no guaranthe results of the above operation, treatment(s) or procedure(s).</li> </ol>	ions, and consequences that are attendant to the per- ntees or assurances have been made to me concerning
<ol> <li>I further consent to the adminstration of such anesthesia and/or I recognize that there are always risks to life and health associated have been explained to me.</li> </ol>	blood transfusions as may be considered necessary, with anesthesia and blood transfusions and such risks
<ol> <li>I further consent to disposal by hospital authorities, or possible use tomed practice, of any tissues or parts which may be removed.</li> </ol>	e for research purposes, in accordance with its accus-
<ol> <li>I confirm that I have read and fully understand the above and the my signing. I have crossed out any paragraphs above which do not pe</li> </ol>	nat all the blank spaces have been completed prior to rtain to me.
Interpreter if required SIGNATURE 0	Patient/Relative or Guardian •
PRINT NAME AND ADDRESS	PRINT NAME
Witness	RELATIONSHIP IF SIGNED BY PERSON OTHER THAN PATIENT
PRINT NAME	)//5/5.,
I hereby certify that I have explained the nature, purpose, benefits operation, have offered to answer any questions and have fully answer guardian fully understand what I have explained and answered.	erieles ad sand alamanation of the sand alamanation of
Physician Sen	th Stand 7/15/5,
REMARKS: PRINT NAME	DATE
	c06074